AMENDED IN SENATE APRIL 11, 2011

AMENDED IN SENATE MARCH 24, 2011

SENATE BILL No. 923

Introduced by Senator De León

February 18, 2011

An act to amend Section 5307.1 of the Labor Code, relating to workers' compensation.

LEGISLATIVE COUNSEL'S DIGEST

SB 923, as amended, De León. Workers' compensation: official medical fee schedule: physician services.

Existing law establishes a workers' compensation system, administered by the Administrative Director of the Division of Workers' Compensation, to compensate an employee for injuries sustained in the course of his or her employment.

Existing law requires the administrative director, after public hearings, to adopt and revise periodically an official medical fee schedule that establishes reasonable maximum fees paid for medical services, other than physician services, and other prescribed goods and services, in accordance with specified requirements.

Existing law, notwithstanding the above provisions, further authorizes the administrative director, after public hearings, to adopt and revise, no less frequently than biennially, an official medical fee schedule for physician services, in accordance with specified requirements.

This bill would instead require the administrative director~~, at an unspecified date,~~ to adopt and revise, no less frequently than biennially *beginning January 1, 2012*, an official medical fee schedule for physician services based on the resource-based relative value scale, as defined, would prohibit the administrative director from adopting an

official medical fee schedule for physician services using conversion factors, as defined, that are less than prescribed conversion factors, and would delete obsolete provisions relating to the adoption of a medical fee schedule for inpatient facility fees *for burn cases*.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. This act shall be known and may be cited as the Fair Fee Schedule for Workers' Compensation Physicians Act.

SEC. 2. The Legislature finds and declares all of the following:

(a) The amount payers are required to pay to physicians providing primary care to injured workers in California is wholly dependent on the statewide official medical fee schedule for physician services as determined from time to time by the Administrative Director of the Division of Workers' Compensation.

(b) California's official medical fee schedule for primary care workers' compensation physician services is currently the second lowest in the nation, even while California providers have the highest cost of providing medical services to injured workers. The current reimbursement rates for workers' compensation physicians in California are nearly 50 percent lower than those in the nearby states of Oregon and Washington.

(c) California's primary care workers' compensation physicians have not had a meaningful fee schedule increase in over 11 years, while the California Consumer Price Index has increased 33 percent over that period. This has resulted in a steady decrease in real income for the state's primary care workers' compensation physicians.

(d) This inequity is causing physicians to abandon the practice of primary care occupational medicine, resulting in diminished access to low-cost, high-quality care for California's injured workers. Without fee schedule relief, primary care workers' compensation physicians will continue to leave the occupational medicine practice, resulting in increased use of far more costly alternatives, including, but not limited to, hospital emergency rooms, and increased time away from work. Once primary care providers leave the occupational medicine practice, the damage to California's workers' compensation system will be irreparable.

(e) California's primary care workers' compensation physicians are the gatekeepers to the state's workers' compensation system, serving as case managers for injured workers and returning them to gainful employment as quickly as possible, thereby controlling total case costs. Without fee schedule relief, California will suffer higher total injury case costs that will result in increased insurance premiums to employers throughout California.

(f) Subdivision (*l*) of Section 5307.1 provides the Administrative Director of the Division of Workers' Compensation with authority to adopt and revise, no less frequently than biennially, an official medical fee schedule for physician services. Pursuant to this authority, the Division of Workers' Compensation has developed a new official medical fee schedule for physician services in California based on the resource-based relative value scale (RBRVS). The RBRVS is widely recognized as the best model for fair and proper allocation of resources for physician payment. It is currently used by the federal Centers for Medicare and Medicaid Services, and in 33 other states' workers' compensation physician services fee schedules.

(g) It is the intent of the Legislature to address these issues by adopting the Fair Fee Schedule for Workers' Compensation Physicians Act.

SEC. 3. Section 5307.1 of the Labor Code is amended to read:

5307.1. (a) The administrative director, after public hearings, shall adopt and revise periodically an official medical fee schedule that shall establish reasonable maximum fees paid for medical services other than physician services, drugs and pharmacy services, health care facility fees, home health care, and all other treatment, care, services, and goods described in Section 4600 and provided pursuant to this section. Except for physician services, all fees shall be in accordance with the fee-related structure and rules of the relevant Medicare and Medi-Cal payment systems, provided that employer liability for medical treatment, including issues of reasonableness, necessity, frequency, and duration, shall be determined in accordance with Section 4600. Commencing January 1, 2004, and continuing until the time the administrative director has adopted an official medical fee schedule in accordance with the fee-related structure and rules of the relevant Medicare payment systems, except for the components listed in subdivision (j), maximum reasonable fees shall be 120 percent of the estimated

aggregate fees prescribed in the relevant Medicare payment system for the same class of services before application of the inflation factors provided in subdivision (g), except that for pharmacy services and drugs that are not otherwise covered by a Medicare fee schedule payment for facility services, the maximum reasonable fees shall be 100 percent of fees prescribed in the relevant Medi-Cal payment system. Upon adoption by the administrative director of an official medical fee schedule pursuant to this section, the maximum reasonable fees paid shall not exceed 120 percent of estimated aggregate fees prescribed in the Medicare payment system for the same class of services before application of the inflation factors provided in subdivision (g). Pharmacy services and drugs shall be subject to the requirements of this section, whether furnished through a pharmacy or dispensed directly by the practitioner pursuant to subdivision (b) of Section 4024 of the Business and Professions Code.

(b) In order to comply with the standards specified in subdivision (f), the administrative director may adopt different conversion factors, diagnostic related group weights, and other factors affecting payment amounts from those used in the Medicare payment system, provided estimated aggregate fees do not exceed 120 percent of the estimated aggregate fees paid for the same class of services in the relevant Medicare payment system.

(c) Notwithstanding subdivisions (a) and (d), the maximum facility fee for services performed in an ambulatory surgical center, or in a hospital outpatient department, shall not exceed 120 percent of the fee paid by Medicare for the same services performed in a hospital outpatient department.

(d) If the administrative director determines that a medical treatment, facility use, product, or service is not covered by a Medicare payment system, the administrative director shall establish maximum fees for that item, provided that the maximum fee paid shall not exceed 120 percent of the fees paid by Medicare for services that require comparable resources. If the administrative director determines that a pharmacy service or drug is not covered by a Medi-Cal payment system, the administrative director shall establish maximum fees for that item. However, the maximum fee paid shall not exceed 100 percent of the fees paid by Medi-Cal for pharmacy services or drugs that require comparable resources.

(e) Prior to the adoption by the administrative director of a medical fee schedule pursuant to this section, for any treatment, facility use, product, or service not covered by a Medicare payment system, including acupuncture services, or, with regard to pharmacy services and drugs, for a pharmacy service or drug that is not covered by a Medi-Cal payment system, the maximum reasonable fee paid shall not exceed the fee specified in the official medical fee schedule in effect on December 31, 2003.

(f) Within the limits provided by this section, the rates or fees established shall be adequate to ensure a reasonable standard of services and care for injured employees.

(g) (1) (A) Notwithstanding any other law, the official medical fee schedule shall be adjusted to conform to any relevant changes in the Medicare and Medi-Cal payment systems no later than 60 days after the effective date of those changes, provided that both of the following conditions are met:

(i) The annual inflation adjustment for facility fees for inpatient hospital services provided by acute care hospitals and for hospital outpatient services shall be determined solely by the estimated increase in the hospital market basket for the 12 months beginning October 1 of the preceding calendar year.

(ii) The annual update in the operating standardized amount and capital standard rate for inpatient hospital services provided by hospitals excluded from the Medicare prospective payment system for acute care hospitals and the conversion factor for hospital outpatient services shall be determined solely by the estimated increase in the hospital market basket for excluded hospitals for the 12 months beginning October 1 of the preceding calendar year.

(B) The update factors contained in clauses (i) and (ii) of subparagraph (A) shall be applied beginning with the first update in the Medicare fee schedule payment amounts after December 31, 2003.

(2) The administrative director shall determine the effective date of the changes, and shall issue an order, exempt from Sections 5307.3 and 5307.4 and the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), informing the public of the changes and their effective date. All orders issued pursuant to this paragraph shall be published on the Internet Web site of the Division of Workers' Compensation.

(3) For the purposes of this subdivision, the following definitions apply:

(A) "Medicare Economic Index" means the input price index used by the federal Centers for Medicare and Medicaid Services to measure changes in the costs of a providing physician and other services paid under the resource-based relative value scale.

(B) "Hospital market basket" means the input price index used by the federal Centers for Medicare and Medicaid Services to measure changes in the costs of providing inpatient hospital services provided by acute care hospitals that are included in the Medicare prospective payment system.

(C) "Hospital market basket for excluded hospitals" means the input price index used by the federal Centers for Medicare and Medicaid Services to measure changes in the costs of providing inpatient services by hospitals that are excluded from the Medicare prospective payment system.

(h) This section does not prohibit an employer or insurer from contracting with a medical provider for reimbursement rates different from those prescribed in the official medical fee schedule.

(i) Except as provided in Section 4626, the official medical fee schedule shall not apply to medical-legal expenses, as that term is defined by Section 4620.

(j) The following Medicare payment system components shall not become part of the official medical fee schedule until January 1, 2005:

(1) Inpatient skilled nursing facility care.

(2) Home health agency services.

(3) Inpatient services furnished by hospitals that are exempt from the prospective payment system for general acute care hospitals.

(4) Outpatient renal dialysis services.

(k) Notwithstanding subdivision (a), for the calendar years 2004 and 2005, the existing official medical fee schedule rates for physician services shall remain in effect, but these rates shall be reduced by 5 percent. The administrative director may reduce fees of individual procedures by different amounts, but shall not reduce the fee for a procedure that is currently reimbursed at a rate at or below the Medicare rate for the same procedure.

(*l*) (1) Notwithstanding subdivision (a), the administrative ~~director, commencing _____~~ *director* shall adopt and revise, no

less frequently than biennially *beginning January 1, 2012*, an official medical fee schedule for physician services that is based on the resource-based relative value scale. The administrative director shall not adopt an official medical fee schedule for physician services using conversion factors that are less than the following:

(A) For physician services other than anesthesiology ~~and radiology~~, the minimum conversion factors are as follows:

	~~Surgery~~	~~All other physician services~~
~~2012~~	~~57.75~~	~~55.5~~
~~2013~~	~~58.5~~	~~57~~
~~2014~~	~~59.25~~	~~58.5~~
~~2015 and after~~	~~60~~	~~60~~

	Surgery	*Radiology*	*All other physician services*
2012	*57*	*57.75*	*46.5*
2013	*58*	*58.5*	*51*
2014	*59*	*59.25*	*55.5*
2015 and after	*60*	*60*	*60*

(B) For anesthesiology services, the minimum conversion factor is 34.

~~(C) For radiology services, the minimum conversion factor is 60.~~

(2) The administrative director shall adjust the official medical fee schedule to conform to any relevant changes in the Medicare and Medi-Cal payment systems no later than 60 days after the effective date of those changes, provided that in no event shall a change in a payment system reduce the existing reimbursement rate payable to workers' compensation physicians.

(3) For purposes of this subdivision, the following definitions apply:

(A) "Conversion factor" means the number that is multiplied by the relative value to produce the reimbursement rate payable to workers' compensation physicians, except that for anesthesiology services, "conversion factor" means base units plus time units.

(B) "Resource-based relative value scale" means the relative value scale created by the federal Centers for Medicare and

Medicaid Services and set forth in the Federal Register for each calendar year.

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